New Hampshire

LYRICA® (Pregabalin)

NH Medicaid Prior Authorization

Request Form

First Health Services Corporation
A Coventry Health Care Company

Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ___ ___ /___ ___ /___ ___

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____ NH Medicaid Number:___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name:_____ Strength:_____

Dosing Directions:_____ Length of Therapy:_____

Section II: Clinical History:

1. Does patient have a diagnosis of partial onset seizures? (If yes, please go to section III) ☐ Yes ☐ No
2. Does patient have a diagnosis of post-herpetic neuralgia? (If yes, please go to question #9) ☐ Yes ☐ No
3. Does patient have a diagnosis of diabetic peripheral neuropathy? (If yes, please go to question #9) ☐ Yes ☐ No
4. Does patient have a diagnosis of fibromyalgia? (If yes, continue to question #5) ☐ Yes ☐ No
5. Has widespread pain been present for at least 3 months? ☐ Yes ☐ No
6. Is pain present in at least 11 out of the 18 specific tender points (according to ACR guidelines)? ☐ Yes ☐ No
7. Describe any physical fitness interventions that have been done: _____
8. Describe any behavioral health interventions: _____
9. If yes to question(s) # 2 or #3, has the patient experienced a treatment failure, or is not a candidate for, treatment with at least two of the following agents: tricyclic antidepressant, Lidoderm®, gabapentin, or tramadol? ☐ Yes ☐ No

   Please describe treatment failure and provide dates (use a separate sheet if additional space is required):

   _____
   _____

10. If yes to question #4, has the patient experienced a treatment failure, or is not a candidate for treatment with at least two of the following agents: amitriptyline, cyclobenzaprine, fluoxetine, citalopram, and tramadol? ☐ Yes ☐ No

    Please describe treatment failure, provide the dosage used, and provide dates (use a separate sheet if additional space is required):

    _____
    _____

11. Is there any additional information that would help in the decision-making process? (use a separate sheet if additional space is required):

    _____
    _____
    _____

Section III: Prescriber Information:

Name: _____ **DEA** Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider